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MEETING THE CHALLENGE: GROWTH & PROGRESS

Medical Assistance Program
1984, 1985, 1986

Edward T. Duffy
Director

Illinois Department of Public Aid

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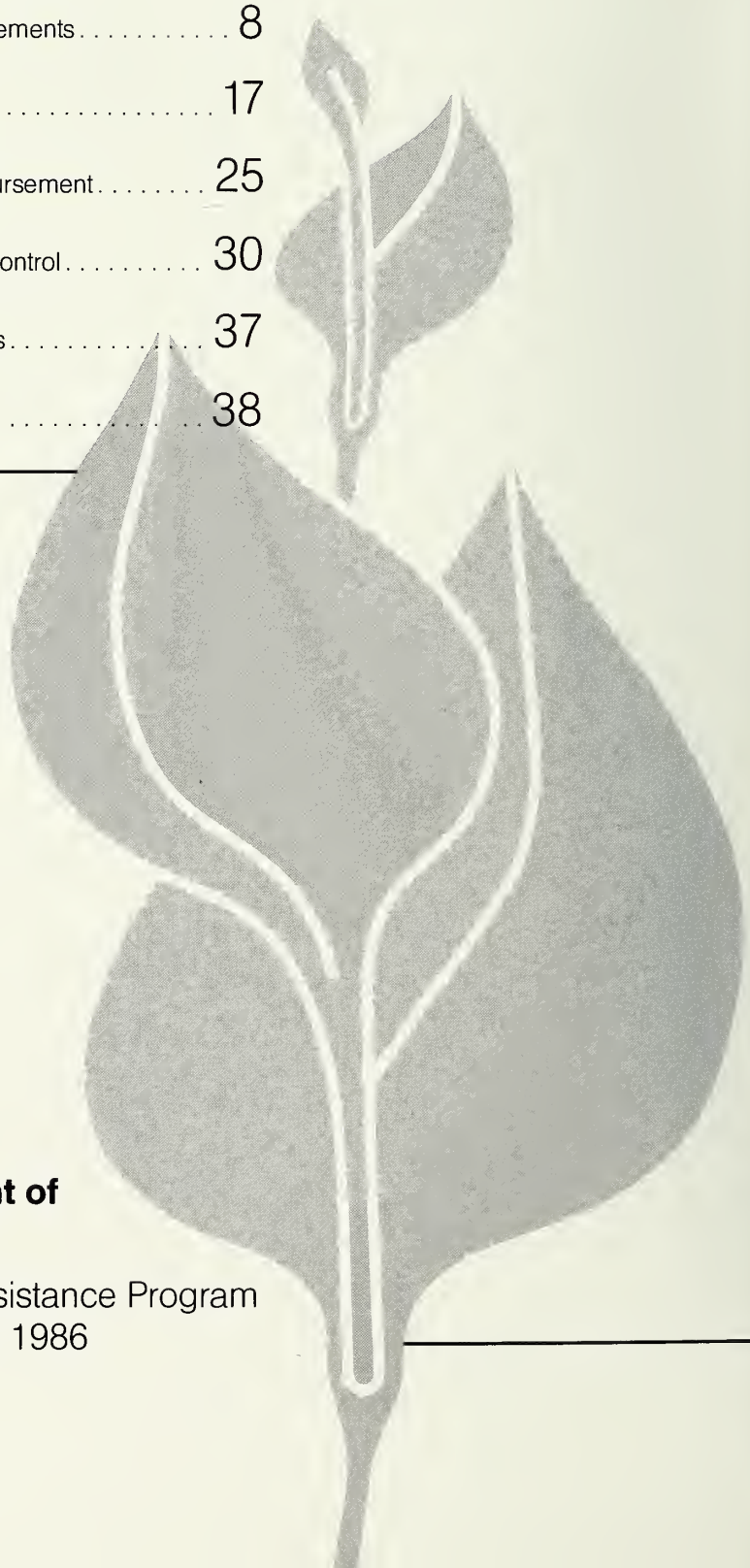

Illinois Department of Public Aid

Medical Assistance Program
1984, 1985, 1986

Message from the

To the Honorable Members of the General Assembly:

I am pleased to present you with the Department of Public Aid's annual report on the Medical Assistance Program for 1984, 1985, and 1986.

Over the last three years, the Department has aggressively taken steps to see that Illinois' needy receive the best medical care available. At the same time, Public Aid has pursued avenues leading to savings for Illinois' taxpayers. Together, these two actions have resulted in significant progress in a number of areas:

- Hospital contracting (ICARE) negotiations were concluded last year resulting in an $84 million savings.
- Quality long term care took step forward as the Quality Program (QUIP) inspections remarkable increase in the five and six star winners.
- Illinois' children got a boost Healthy Kids Program when significantly increased its bu ensure that all children — ev hard-to-serve children — re physical examinations and immunizations.
- A restructured optical care was implemented resulting substantial savings to the S the purchase of glasses an improving recipients' acces doctors.

Ensuring quality medical care providing efficient manageme dollars is an enormous unde With your continued support, Department of Public Aid will successfully meet this challe

Sincerely,

Edward T. Duffy
Director

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Overview

The Illinois Department of Public Aid's Medical Assistance Program serves those who receive cash grants and those not eligible for cash assistance but who cannot afford medical care. This means that each month, the Medical Assistance Program makes essential medical care available to over one million people at an annual cost of almost $1.8 billion. Medical services are provided by 26,500 providers, including nearly 18,000 physicians.

The Department offers a wide range of medical coverage to its clients. This includes all of the nine mandatory and all but two of the 28 optional services available under Medicaid. (See Table V.)

All of the medical services are provided by licensed practitioners, licensed facilities, or other non-institutional providers enrolled to participate in the State's program. (Table IV lists providers by year and type of service.)

The Department administers the program under the Illinois Public Aid Code and Title XIX of the Social Security Act. Medical care for AFDC and AABD recipients is funded jointly by the state and federal governments, while the GA and AMI medical benefits are funded by the State.

The Medical Assistance Program pays for medically necessary services when: the recipient is eligible; the service is covered; and the provider is enrolled to provide that service.

Client eligibility for medical assistance falls into four major categories:

The Medical Assistance - Grant Program (MAG) includes individuals receiving income assistance through AFDC, AABD, or the Refugee Program. A monthly average of 790,424 individuals met the requirements for receiving medical services through MAG in Fiscal Year 1986.

The Medical Assistance - No Grant Program (MANG) serves individuals who meet all categorical criteria for AFDC, AABD, or Refugee Assistance. The income of these people is sufficient to meet basic needs, but medical expenses exceed their ability to pay. Approximately 222,534 individuals each month qualified for medical services through MANG in Fiscal Year 1986.

The General Assistance Medical Program (GA-MED) includes people receiving income assistance grants through the General Assistance Program. A monthly average of 112, 523 individuals in Fiscal Year 1986 qualified for GA-MED.

The Aid to the Medically Indigent Program (AMI) serves people who are not eligible for MAG, MANG, or GA-MED, but whose incomes are not sufficient to meet medical expenses. AMI served a monthly average of 18,861 individuals in Fiscal Year 1986.

Over one million people receive medical services provided by 26,500 providers including nearly 18,000 physicians.

The Year at a Glance

January

The Department of Public Aid began 1986 by signing 26 Illinois Competitive Access and Reimbursement Equity (ICARE) contracts with hospitals in the Metro East St. Louis area. ICARE, the Department's innovative approach to putting a cap on hospital expenditures and simultaneously improving medical care for the needy, had by this time brought an estimated savings of $84 million to the State.

The Department announced a five percent rate increase for providers of optical services. The amount of the increase was applied to the maximum allowable rate of reimbursement for examinations and dispensing fees only. These increases were made retroactive for dates of services provided on or after July 1, 1985.

Three new contracts with Health Maintenance Organizations in Cook and the collar counties became effective in January, May, and June. This action helped expand preventive health care services to over 100,000 clients in the State (as of November 1986).

March

Building on the immense success of the first Governor's Conference on Long Term Care, the Department took the lead in hosting the second annual Governor's Conference, "Continuing The Course for Quality." The conference attracted nearly 1,000 nursing home administrators, nursing directors, nurses and individuals with a professional interest in long term care. The conference had over 50 workshops and focused on private and state initiatives designed to improve the quality of long term care.

April - May

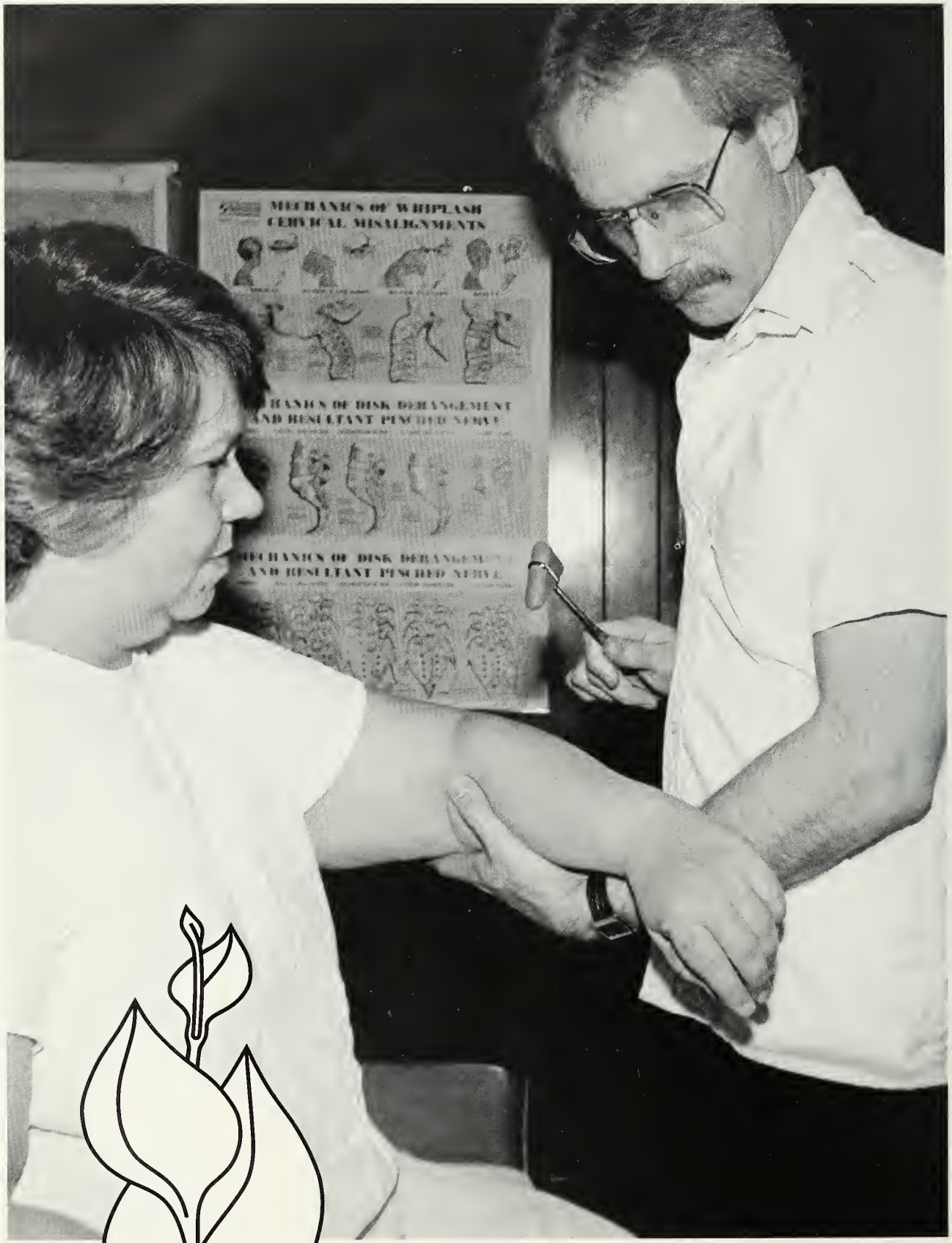
To better serve the Department's clients, the ICARE Program was expanded. Effective April 1, 1986, the ICARE Program was extended to hospitals located in the Illinois counties of Mercer, Rock Island, Henry, Winnebago, Boone, Ogle, McHenry, Lake, Kane, Kendall, Grundy, Will, and Kankakee; the Wisconsin counties of Green, Rock, Walworth, and Kenosha; the Iowa counties of Scott, Muscatine, Louisa, and Clinton; and the Indiana counties of Newton and Jasper.

Hospital rules were revised to allow recipients admitted to a non-contracting hospital for a "true emergency" to remain in that same hospital for up to five days after emergency services are no longer required. Previous rules required patients to be transferred to a contracting hospital when emergency services were no longer needed. Under modified policies, non-contracting hospitals can receive full payment during those five days after the emergency.

June

The Department announced that it had signed ICARE contracts with 33 hospitals in the central Illinois region and one hospital in Iowa, effective on June 15, 1986.

ICARE is the Department's innovative approach to putting a cap on hospital expenditures and simultaneously improving medical care for the needy.


MECHANICS OF WHIPLASH
CERVICAL MISALIGNMENTS

July

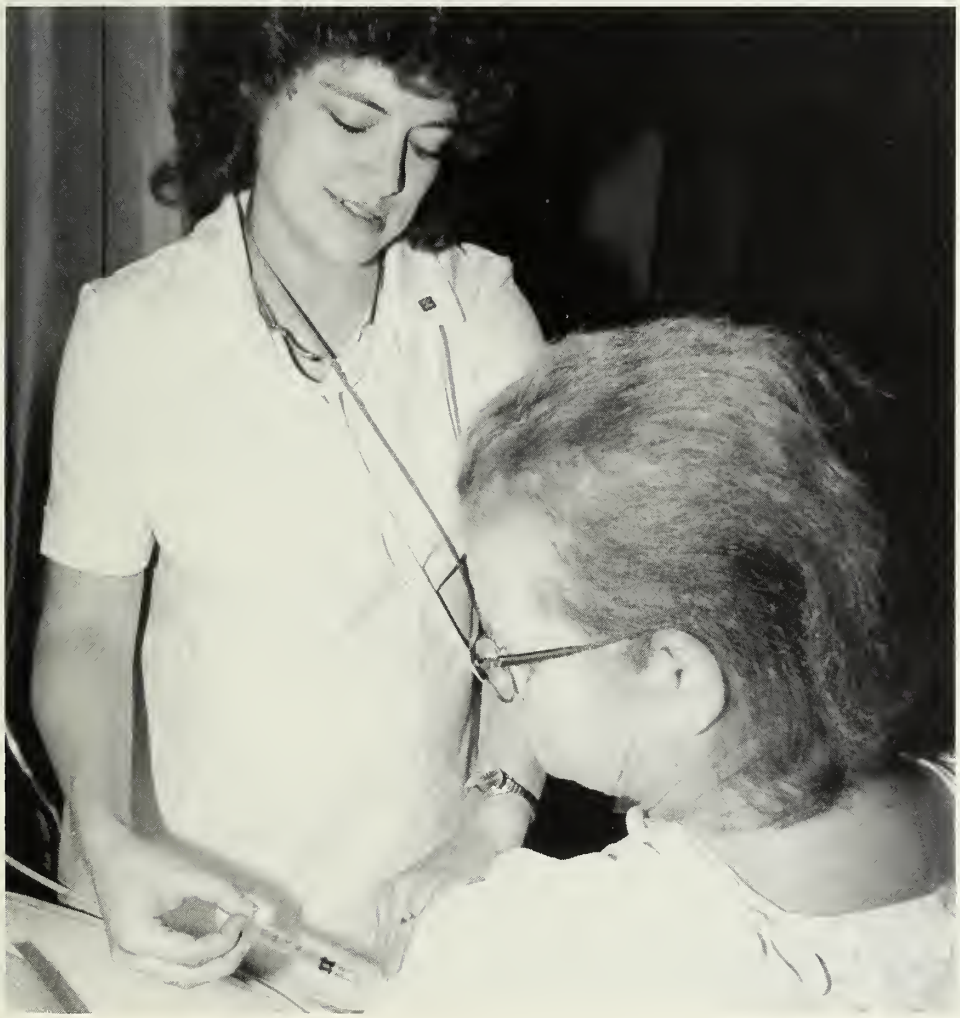
Better access to eyeglasses for recipients and a savings of tax dollars was the result of an agreement between the Department of Public Aid and the Department of Corrections. Inmates at the Dixon Correctional Facility will make the glasses at an estimated savings of $3 per pair. Public Aid has purchased approximately 80,000-100,000 pairs each year. Because of the low level of reimbursement, recipients have had difficulty finding optometrists who will serve them. With these savings, the State will be able to raise the fees paid to optometrists increasing accessibility to care for the Department's clients.

The Department announced that effective July 1, 1986, the maximum allowable rate for chiropractic spine manipulation was increased from $8.80 to $9.25.

The Department announced the revision of its patient assessment instrument used in reimbursing nursing homes for providing direct patient care services. The new policies offer incentives for nursing homes to provide rehabilitative services to clients and ensure needed services are available.

August

Cooperation between the Departments of Public Aid and Veterans' Affairs built a VA outreach program aimed at maximizing veterans' benefits for any veteran, widow(er), or spouse of a veteran who is a patient in a nursing home.



September - October

Because residents in long term care facilities are at high risk of contracting influenza, the Department again provided influenza vaccine for recipients residing in nursing homes. This is the third year that Public Aid has provided this service.

November - December

Under the Healthy Kids Program, reimbursement rates for physician services were increased for screenings, immunizations and elective procedures. An intense effort to reach all eligible children — even the hard-to-find children — is part of Healthy Kids. The Department's priority is to give kids a healthy start in life.

The Department and Sangamon State University's Center for Policy Studies and Program Evaluation sponsored the first Illinois Long Term Care Research Symposium. The Symposium brought together state officials, academicians, and providers of long term care to discuss the results of Fiscal Year 1986 Long Term Care Research and Demonstration Projects.

New Department policies offer incentives for nursing homes to provide rehabilitative services to clients.

Program Achievements

Hospital Contracting

ICARE (the Illinois Competitive Reimbursement Equity Program) is the result of the combined efforts of the Illinois legislature, the Governor's Office, Illinois business and labor, the Illinois State Medical Society and the Illinois Hospital Association. ICARE allows the Department to use competition among hospitals in negotiating for the purchase of medical care for Department clients. Traditionally, hospitals have been shielded from many economic market forces by cost-based and third party payment systems that insulated them from normal concerns for economy and efficiency. During 1985, the Illinois Department of Public Aid successfully moved away from cost-based hospital reimbursement with the implementation of the ICARE Program.

This innovative approach to the purchase of inpatient hospital services for recipients has improved access to care and reduced the costs to taxpayers. The benefits of the ICARE Program have been documented by an independent review which identified savings at $84 million. The review also documented that the Department had successfully shifted routine care from high-cost to low-cost hospital settings while ensuring that both emergency treatment and specialized care continued to be available.

The Department conducted ICARE contract negotiations in each of the State's metropolitan areas where a sufficient number of hospitals and patients existed to produce a competitive environment. In each area, all hospitals were invited to negotiate for the Department's business whether or not they had historically participated in the Medicaid Program. The Department has contracts with 183 hospitals covering care including any specialized services for public assistance patients.

In geographic areas of the State where a significant competitive environment does not exist, the Department's cost-based, prospective rate system continues to be used to purchase hospital care.

Quality Long Term Care

One of the Department's continuing goals is to provide quality long term care to those who need it but cannot afford it. In Fiscal Year 1985, the Department implemented a number of program changes in order to achieve its goal. During Fiscal Year 1986, the Department strengthened those initiatives:

- Inspection of Care,
- Case Management,
- QUIP,
- Governor's Conference on Long Term Care,
- Developmental Training Initiatives, and
- Long Term Care Research and Demonstration Projects.

Inspection of Care and Case Management

In Fiscal Year 1985, the Department assumed responsibility for the Inspection of Care (IOC) Program which serves as the federally mandated quality assurance program and as the State's rate making mechanism for nursing services.

The impact of the Case Management Program has been dramatic because the State is able to determine more accurately both what the residents need and what services the facility provides by actually observing both residents and facility staff. The IOC Program is implemented through the Department's Case Management Program staff. Staff are assigned to an average of eight long term care facilities which they visit at least 24 times per year to consult, to conduct assessments on all of the residents, and to gather information necessary to calculate a facility's payment rate.

The Case Management Program allows Department nurses to give constant attention to the daily events which shape each resident's experience. After interviewing each resident personally, the nurses make recommendations on the quality of care given to the residents and encourage facility practices that promote resident independence.

The initial outcome of having case managers conduct resident assessments is a much healthier population than when these assessments were completed by staff who visited the facility only once or twice a year. As the following table shows, the percentage of residents needing skilled care decreased as they were more frequently assessed.

Percentage of Long Term Care Residents Requiring Different Levels of Care Under Old and New Systems of Reimbursement

Levels of Care	Old System	New System
Skilled Care	15.6%	9.8%
Intermediate Care	81.5%	65.8%
Light Intermediate Care	2.8%	24.4%

Quip

The Quality Incentive Program (QUIP), initiated in 1981, was a milestone in improving the State's long term care system. QUIP promotes superior care by financially rewarding Medicaid-enrolled facilities for demonstrated excellence.

In Fiscal Year 1985, the State committed $9 million for incentive payments. In Fiscal Year 1986 an additional $10 million was approved for incentive payments. Also in Fiscal Year 1986, QUIP was recognized by the Ford Foundation and Harvard University's John F. Kennedy School of Government as being among the ten most innovative programs in state and local government.

To qualify for QUIP payments, facilities must meet the requirements for state licensure and Medicaid participation, and must also be free of serious violations. Additionally, facilities must meet at least 92 percent in the aggregate of each Medicaid resident's needs. Once they meet these minimum criteria, the Department "grades" them with stars in report card style, with six stars being the best. Stars are given in the following six areas:

1. Facility structure and environment;
2. Resident participation and choice;
3. Community and family participation;
4. Resident satisfaction;
5. Resident care planning; and
6. Intensive programs.

Demonstrated quality in each of the first four areas will qualify a facility for an additional $1.00 per day per resident ($.25 per category). The last two areas are divided into two standards each worth an additional $.50.

The Department's case management staff visits each facility two times per year to conduct QUIP surveys. The Department staff uses a consultative approach versus a regulatory one and discusses with the facility the outcome of its QUIP survey. With financial rewards as a tool, facilities have a great deal of incentive to improve their care.

Facilities eager to receive the public recognition associated with being a six-star facility are constantly working to improve their operations. The Department is extremely pleased with the progress demonstrated over the last three QUIP assessments.

Number of Facilities Passing QUIP I Inspection, QUIP II Inspection, and QUIP III Inspection

Facilities Passing Part	QUIP I Achievement 60%	QUIP II Achievement 65%	QUIP III Achievement 70%
I	411	434	410
II	244	366	409
III	142	237	255
IV	481	510	548
V	42	104	111
VI	129	141	155

Governor's Conference on Long Term Care

The Department took the lead in planning the second Governor's Conference on Long Term Care. The conference, "Continuing The Course For Quality," provided a forum for about 1,000 state leaders and providers to examine the whole scope of long term care and then to consolidate their creativity and resources to improve the quality of care.

QUIP promotes superior care by financially rewarding Medicaid-enrolled facilities for demonstrated excellence.

Developmental Training Initiative

In conjunction with the Department of Mental Health and Developmental Disabilities and the Governor's Planning Council on Developmental Disabilites, the Department of Public Aid expanded services to developmentally disabled residents who receive such services. As a result, these programs became eligible for Medicaid reimbursement on July 1, 1985.

Previously, day programs for developmentally disabled nursing home residents were supported through grants-in-aid from the Department of Mental Health and Developmental Disabilities. The conversion allows the expansion of services without increasing state expenditures.

In Fiscal Year 1986, the Department revised its rules governing reimbursement and now reimburses long term care facilities directly for the cost of providing day training services. Furthermore, the Department, through its Day Training Initiative, has opened the lines of communication between long term care facilities and day training agencies. The result has been improved services and continuity of services for developmentally disabled residents.

Long Term Care Research and Demonstration

In Fiscal Year 1985, the Department established the Long Term Care Research Fund to help promote cooperation between researchers and the long term care industry in an effort to improve patient care and to control the State's cost of long term care. Funds were awarded to academic institutions, nursing homes, and private foundations and associations.

The research addressed three priority areas: treatment practices, case management, and facility management.

On November 14, 1986, the Department and Sangamon State University's Center for Policy Studies and Program Evaluation joined to present the first Illinois Long Term Care Research Symposium. The one-day symposium provided a forum for exchanging the results of applied research projects and offered an opportunity for long term care providers, researchers and state program managers to engage in conversation on enhancing care for Illinois' nursing home residents.

The Department plans to disseminate the findings of the research projects to all long term care facilities. The goal is to have the innovative findings and research incorporated into daily facility operations.

Restructuring The Optical Care Program

In 1986, an important initiative was introduced restructuring the Optical Care Program. The Department entered into an agreement with the Illinois Department of Corrections (DOC) to use their newest industry, an optical laboratory located at Dixon Correctional Facility, to fabricate eyeglasses for Public Aid recipients. Before this restructuring, providers of optical services often refused to participate in the Department's program due to inadequate reimbursement for eyeglasses and the out-of-pocket cost that was incurred before such reimbursement could be claimed. Complaints of lack of patient access to care had become a major concern to the Department. This arrangement is expected to provide the following positive results: (1) elimination of the need for providers of eyeglasses to incur out-of-pocket expenses for laboratory costs; (2) potential long term savings which the Department can apply to examination and dispensing fees; (3) more timely provision of eyeglasses resulting from changes in processing policies; and (4) increased provider participation and patient access to services resulting from reduced paperwork.

Providers are being phased-in to the new program based on geographical regions. The first region, consisting of Illinois' southernmost counties of the State, was phased in July 1, 1986. The final region, northern metropolitan Chicago, will be phased-in on May 1, 1987.

The second annual Governor's Conference on Long Term Care provided a forum for nearly 1,000 participants to explore ways of improving the lives of Illinois' disabled and elderly.

The agreement with DOC included establishment of a laboratory fee structure that is lower than the fees previously paid to individual providers. Therefore, a savings has been realized and has made possible an increase in the fee paid to an optometrist for the dispensing of eyeglasses. The program will continue striving to provide quality eyeglasses while realizing additional laboratory savings which can be applied to increases in professional fees. These further increases are viewed by the optometric community as being essential to the achievement of the overall goal of increased patient access.

Prepaid Health Plans

Prepaid health is a full-service program promoting well-managed, cost-effective care through the delivery of medical services by Health Maintenance Organizations (HMOs). HMOs are designed to provide cost-effective services by:

- improving client access to care,
- providing early detection and treatment,
- providing case managed care,
- offering preventive care,
- relying on competitive bidding to control costs,
- improving quality of care by applying quality assurance and peer review standards, and
- requiring contract compliance and quality assurance monitoring to ensure appropriate delivery of services.

In Fiscal Year 1986, the Department contracted with ten HMOs to provide Medicaid services in Cook County and the four collar counties of Will, Lake, Kane and DuPage. In July 1985, the number of AFDC-MAG recipients enrolled in six HMO Medicaid programs was 64,781. The number of AFDC-MAG recipients enrolled as of July 1, 1986, in nine HMO Medicaid programs was 92,637. This is a 43 percent increase in enrollment in one year.

A joint effort between the Departments of Public Aid and Children and Family Services (DCFS) will create an HMO for wards under the care of DCFS. This pilot project will begin in Cook County during Fiscal Year 1988 prior to implementing the program statewide.

During Fiscal Year 1986, the Department planned its approach to monitoring the HMOs. During Fiscal Years 1987 and 1988, each HMO will be monitored for compliance with the contract and a quality assurance measure will be implemented.

Medicaid Home And Community-Based Care

Interagency Home-Based Care Agreements

The Department of Public Aid assumed administrative responsibility under the 1981 Omnibus Reconciliation Act for the Medicaid Home and Community-Based Care Program. The Act granted authority to the U.S. Department of Health and Human Services (HHS) to waive existing statutory requirements so that states could finance non-institutional services for Medicaid-eligible individuals who would otherwise require care in a nursing home or hospital. Under the waiver, 50 percent of the costs for care of Medicaid clients is reimbursed by the federal government, provided that the average cost does not exceed the average cost of institutional care.

Although the Department of Public Aid has supervisory authority for the programs, the day-to-day operation of the program is the responsibility of the Departments of Mental Health and Developmental Disabilities (DMHDD) and Rehabilitation Services (DORS) and the Department on Aging (DOA). As the administering agency for the programs, the Department of Public Aid conducts all communications with the appropriate federal offices, determines financial eligibility of clients, submits all claims for federal matching funds, monitors services and programs, and provides technical assistance to the other agencies.

The services offered through the programs vary with each agency, but include:

- adult day care;
- homemaker and chore/housekeeper;
- case management;
- respite care;
- emergency response;
- habilitation; and
- adaptations to the home.

In 1986, the in-home and the community-based programs for the elderly and the disabled were approved for another three-year period by HHS. Under the new programs, additional adult day care services will be made available for the elderly; and

ventilator-dependent individuals with high service needs will now be eligible for services in the program for the disabled. In addition, both DOA and DORS are working with DPA to increase the number of individuals who are transferred from nursing homes to in-home care programs.

The Program operated by DOA for the elderly serves nearly 16,000 clients and is the largest program in the nation. The Department of Rehabilitation Services expects to serve 2,600 disabled clients in Fiscal Year 1987, while the DMHDD expects that nearly 700 clients will receive services in its program.

Children's Care Model Waiver

After President Reagan brought to national attention the case of Katie Beckett, who was being retained in a hospital because of inflexible regulations in the Medicaid Program, the Department of Health and Human Services established an in-home care program for technologically-dependent children. These children required prolonged hospitalization in the absence of the program. Beginning in 1985, Illinois obtained approval for a model program demonstrating cost-effectiveness which is operated by the Division of Services to Crippled Children of the University of Illinois. The program provides case management, respite care, environmental modification, special equipment, and private duty nursing services as needed. Nearly 40 children were served under the program in Fiscal Year 1987.

Healthy Kids offers preventive health care by encouraging regular medical visits for children.

Healthy Kids Program

The Healthy Kids Program is the name of the Department's federally mandated Early and Periodic Screening, Diagnosis and Treatment Program. The Healthy Kids Program provides periodic health examinations at given intervals as a means of prevention or early diagnosis and treatment of disease for all Medicaid eligible children under the age of 21 years. The program also provides dental care, immunizations, laboratory testing, and hearing and vision screening.

The Department, through cooperation with the Department of Public Health, has two additional program components:

- a vaccine replacement program which permits the timely replacement of vaccines to physicians who administer immunizations, while substantially reducing the replacement cost of the vaccines through volume purchases by the Department of Public Health; and
- a blood lead survey program which permits epidemiological surveys of a child's living environment when the child is diagnosed as having a high level of blood lead.

The Healthy Kids Program is also cooperating with Governor Thompson's Infant Mortality Reduction Initiative. The Department contracted with seven community-based agencies in areas of high infant mortality to deliver outreach, follow-up and case management services. These contractors supplement the efforts of local office staff in assisting clients to utilize the services. The total amount of the contracts is $429,996, of which $100,000 was provided by the Infant Mortality Reduction Initiative through the Department of Public Health.

In an outreach effort, the Department developed a "Passport for Healthy Kids" which is given to all recipients with Medicaid-eligible children under age 21. The "Passport" is their record of medical treatment. A longer, more inclusive medical record booklet has been distributed to all medical providers serving Medicaid-eligible children. An additional outreach effort is the poster of "Healthy Kids" which is displayed in all county Public Aid Offices.

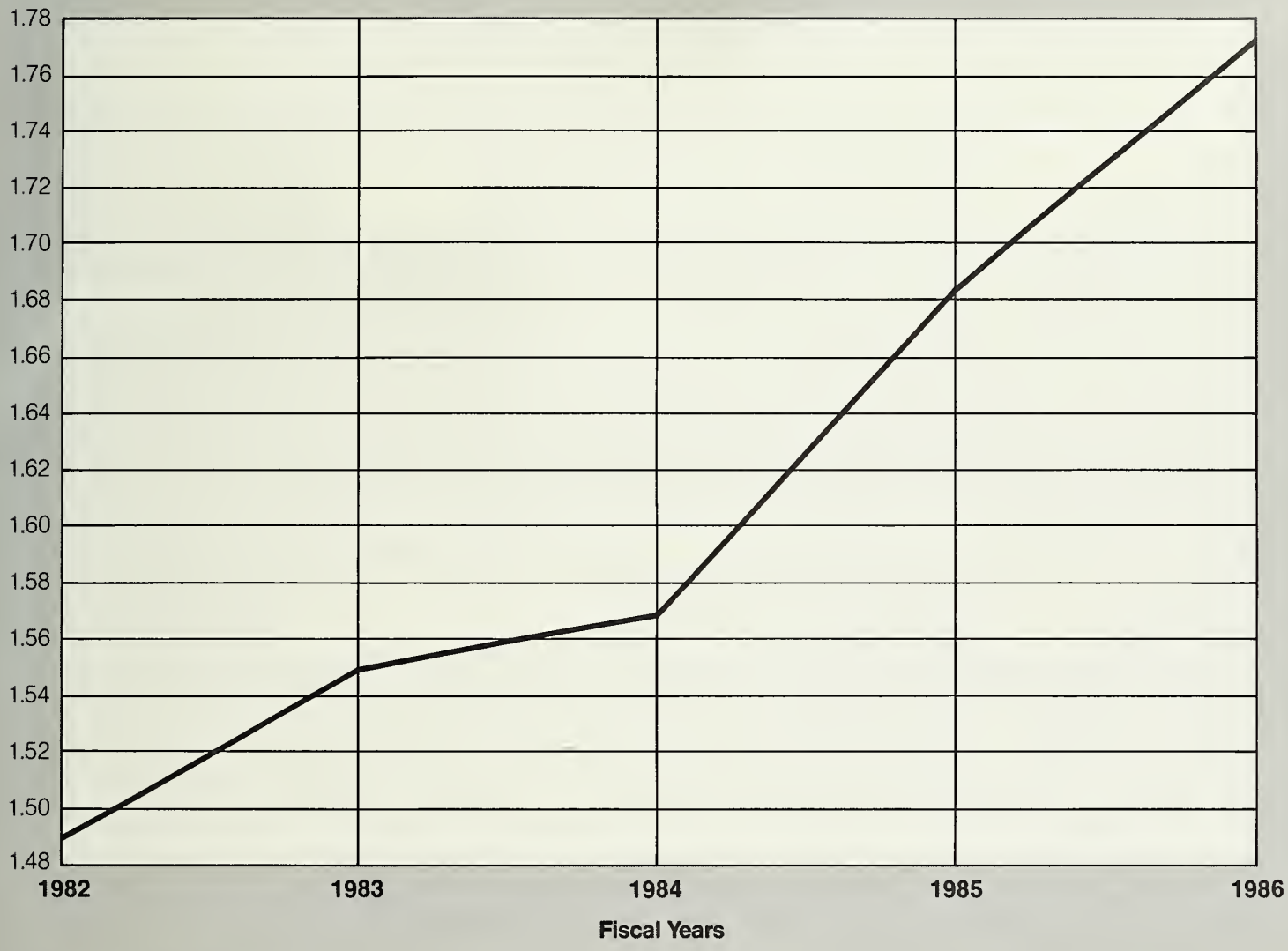
Approximately 630,000 children are eligible for Healthy Kids services. During 1986, 198,054 initial and periodic health screenings were conducted. Of this total, 26,777 screenings (13.5 percent) resulted in the identification of one or more conditions in a child which needed further diagnosis or treatment.

Graph I
Medical Assistance Program

Milestones in Medical Spending

FY 82-FY 86

(Dollars in Billions)



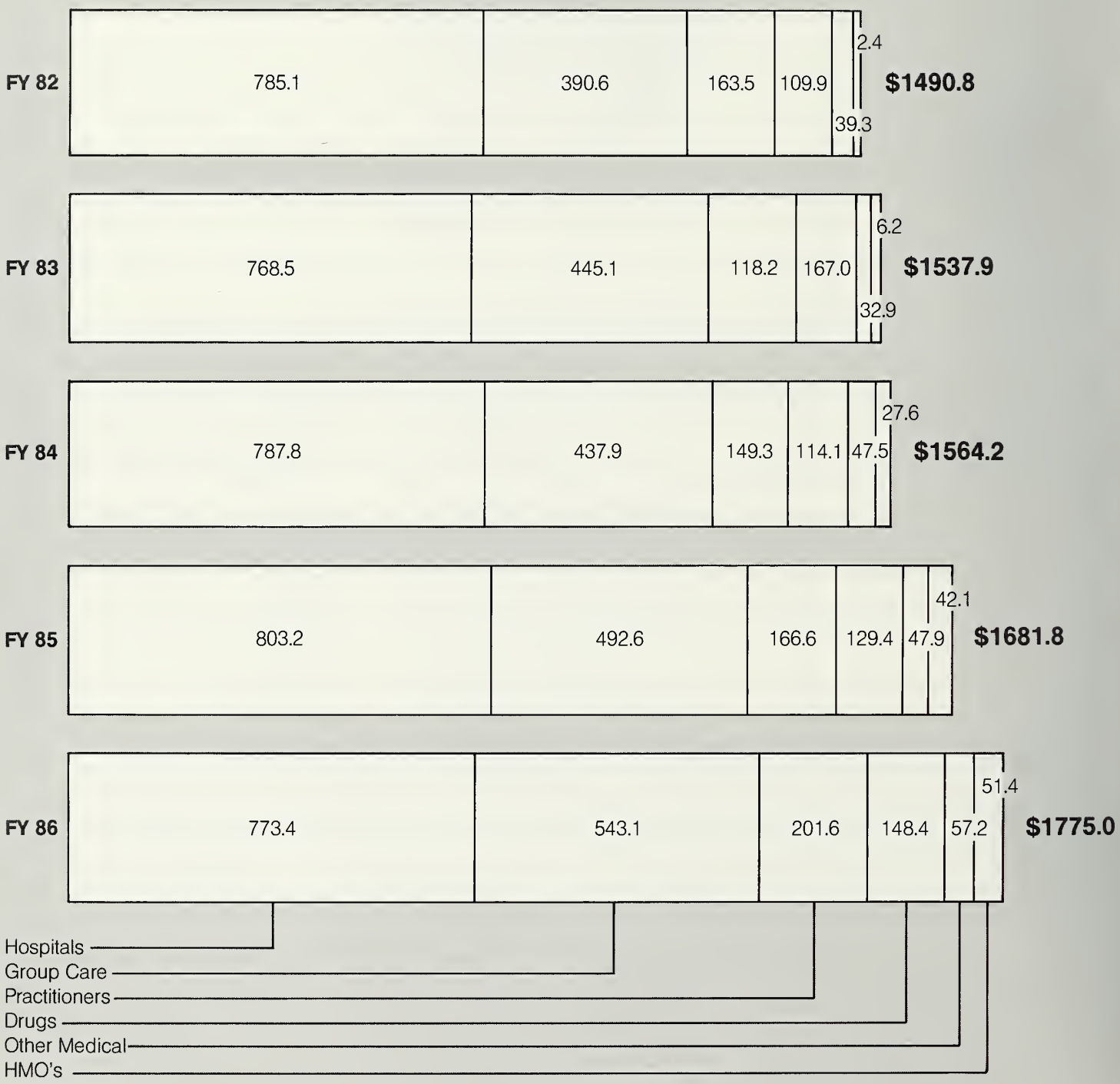
Fiscal Year	Occurrences Which Impacted Spending
1982	Rates were frozen and cost containment measures were implemented which resulted in spending that was less than the previous year.
1983	Due to a depressed economy and high utilization of services, medical expenditures were exceeding available funds. This resulted in the need to reduce rates and restrict some services (the Emergency Budget Act of 1983, or EBA).
1984	Pre-EBA rates and most services were reinstated July 1. However, utilization did not begin to return to pre-EBA levels until the second half of the year.
1985	Non-mandatory rate increases were given for the first time since 1981. Hospital contracting was implemented. Utilization increased throughout the year.
1986	Non-mandatory rate increases were given for another year. Utilization continued to increase.

Graph II

Trend in Medical Expenditures

FY 82-FY 86

(Dollars in Millions)



Graph III

Average Payment Per Claim
by Provider Type
FY 84-FY 86
(In Dollars)

Hospital Inpatient

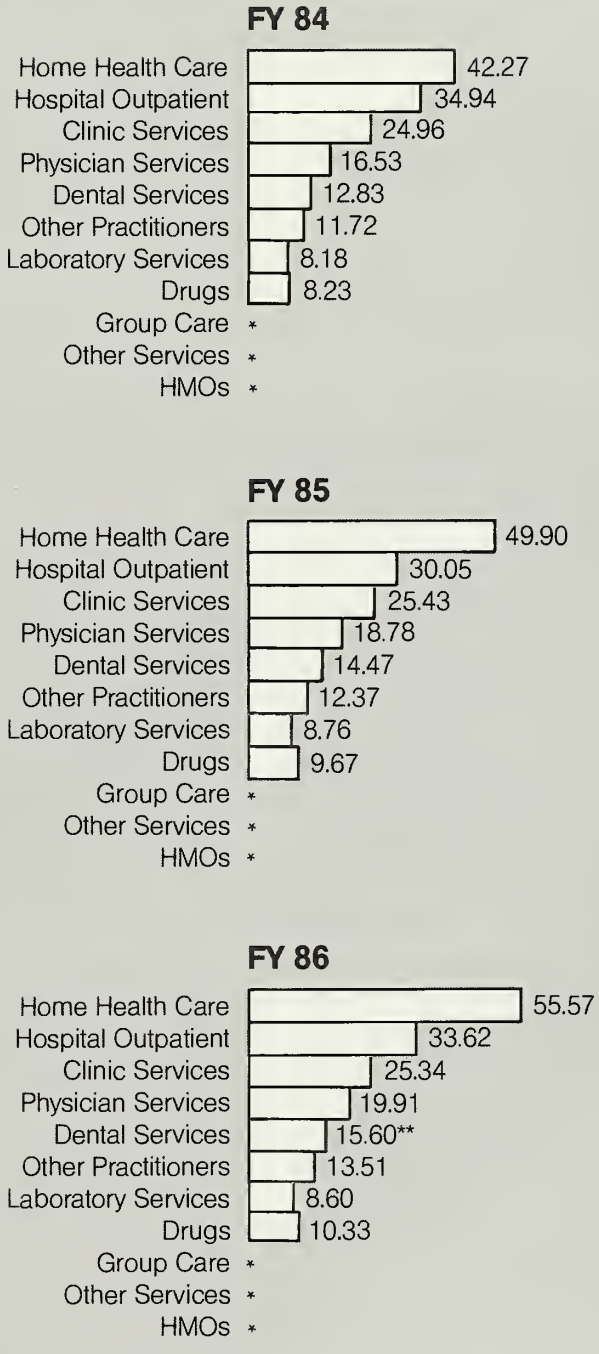
FY 84 $1,599.77

Hospital Inpatient

FY 85 $2048.01

Hospital Inpatient

FY 86 $2034.79

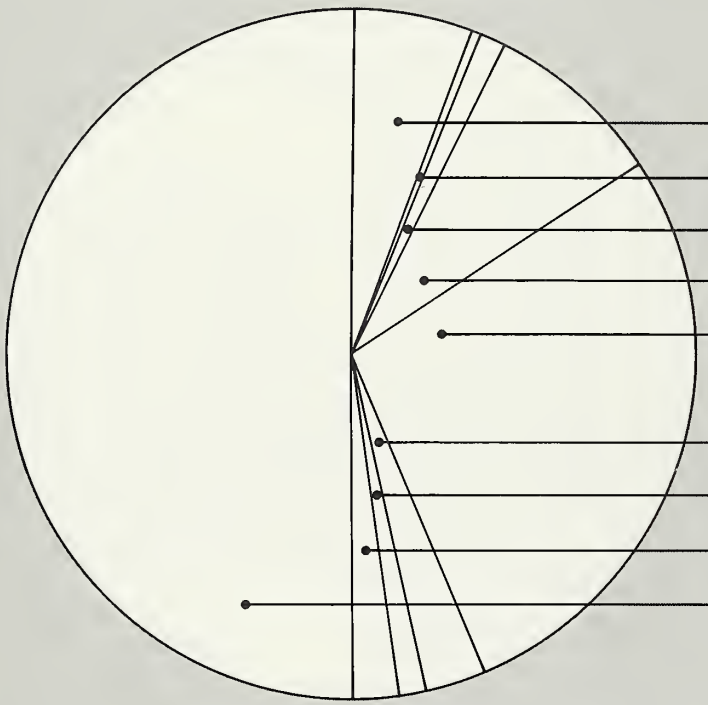


* Group Care, "Other Services" and HMO claims are not reflected in the analysis of the average payment per claim because these services are not measured in terms of claims.

** Beginning in FY 85, Delta Dental Plan of Illinois (a pre paid health plan) provided services to the Medical Assistance-Grant Program (MAG) population. Hence, the average payment presented relates to mostly non-MAG recipient services.

Graph IV

Number of Claims Submitted
by Type of Service
FY 84-FY 86



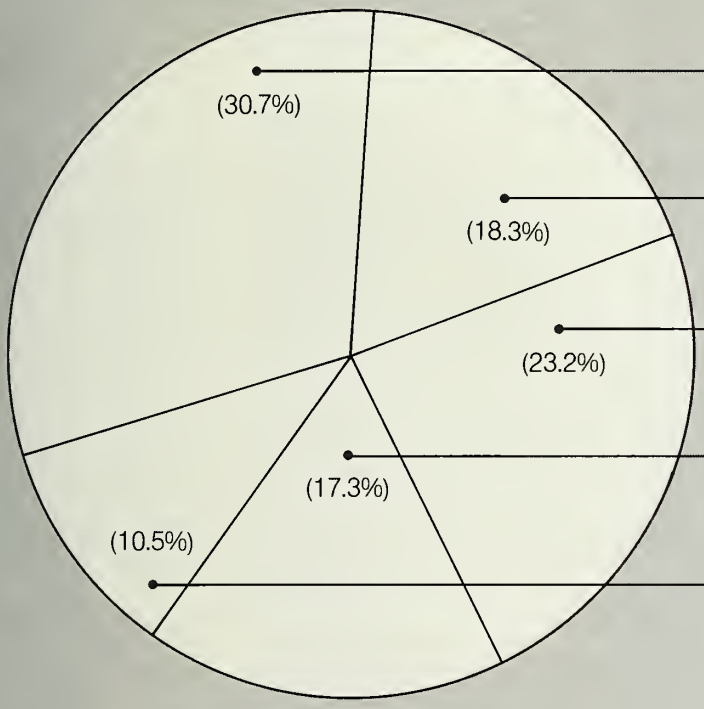
Type of Service	FY 86	FY 85	FY 84
Laboratory Services	1,618,180	1,410,151	1,535,712
Home Health Care	109,293	88,201	72,215
Hospital Inpatient	335,026	349,909	446,228
Hospital Outpatient	2,443,575	2,154,440	1,583,650
Physician Services	8,065,381	7,204,356	7,361,346
Group Care	*	*	*
Clinic Services	867,569	857,939	747,056
Dental Services **	354,091	532,081	1,733,217
Other Practitioners	631,206	486,355	462,825
Drugs	14,571,389	13,383,435	13,865,841
Other Services	*	*	*
HMOs	*	*	*
Total	**28,995,710**	**26,466,867**	**27,808,090**

* Group Care, "Other Services", and HMO claims are not reflected in the analysis of the changing volume of claims to be processed because these services are not measured in terms of claims.

** Beginning in FY 85, Delta Dental Plan of Illinois (a prepaid health plan) provided services to the MAG population. Hence, the claims submitted in FY 85 and 86 were for mostly non-MAG recipient services.

Graph V

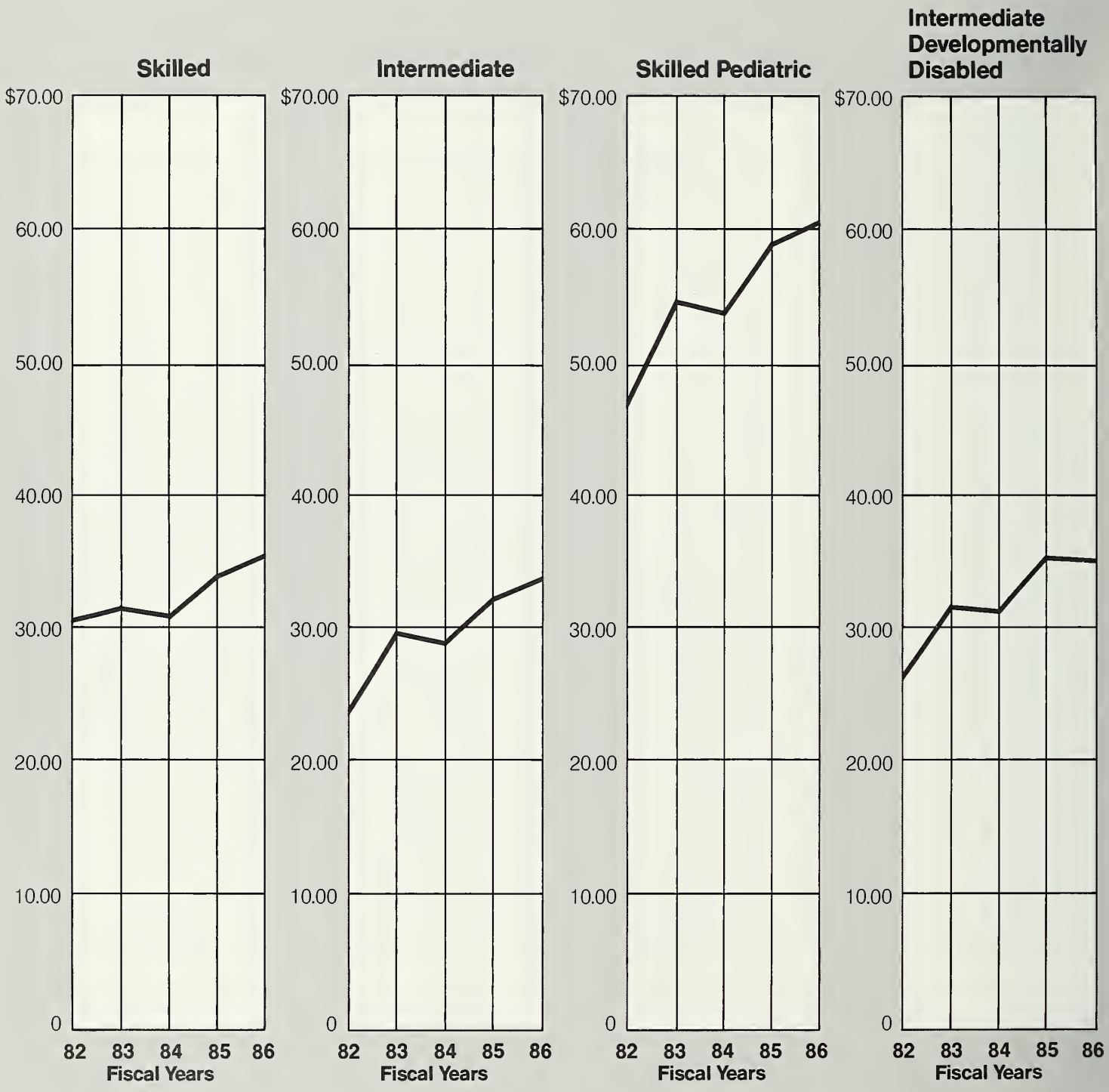
Expenditures for Other Services
Presented by Line Item
FY 84-FY 86



Type of Service FY 86 (Dollars in Millions)		FY 85	FY 84
$11.4	Transportation	$9.9	$9.9
6.8	Medicare Scheduling	6.2	7.8
8.6	Supplemental Medical Insurance Benefit	7.5	7.3
6.4	Appliances	4.6	4.0
3.9	Other Related	3.1	2.9
$37.1	**Total**	**$31.3**	**$31.9**

Graph VI

Nursing Home Average Daily Rate
By Level of Care

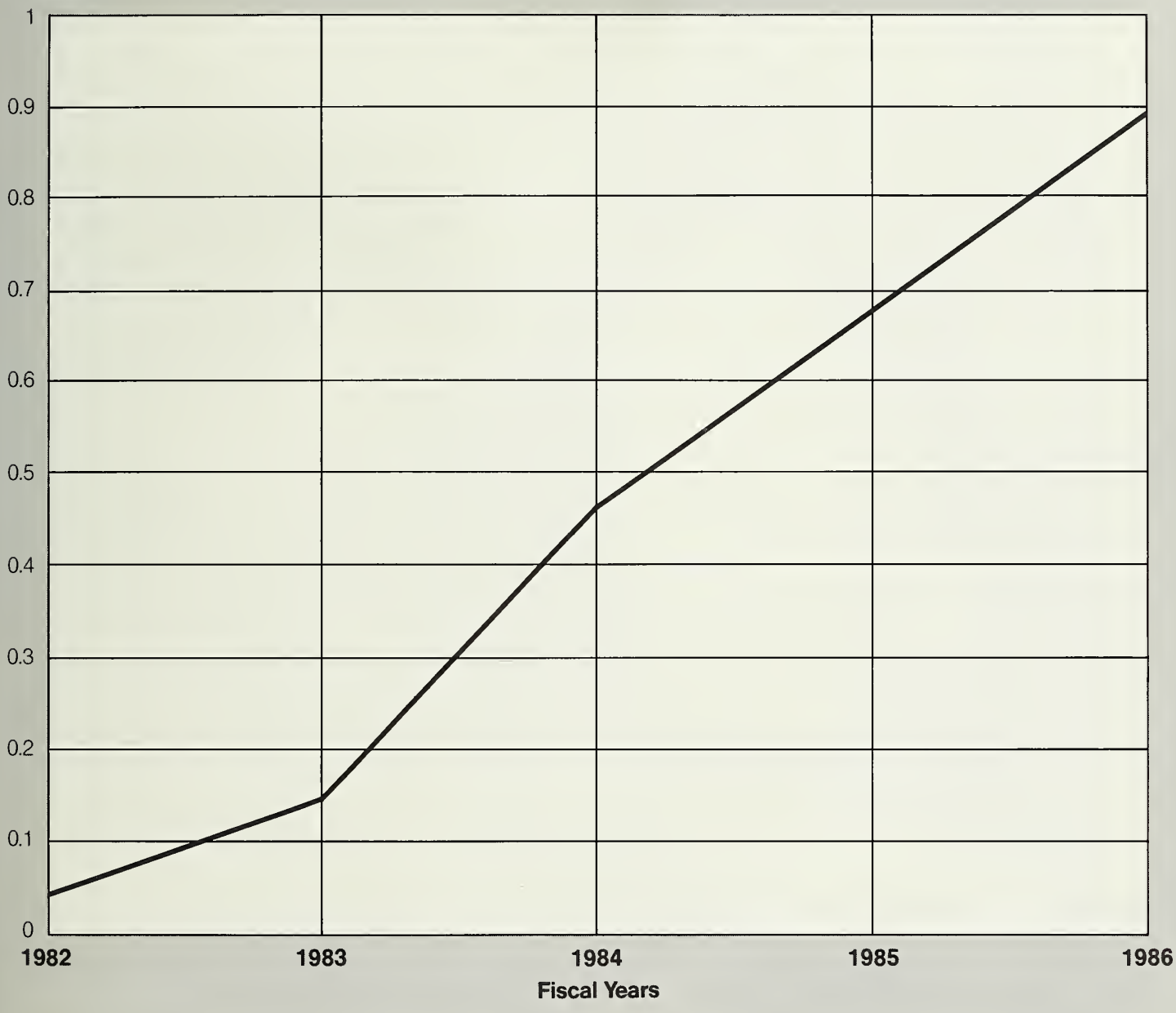


Graph VII

Prepaid Health Plans

Months of Health Maintenance Organization (HMO) Care

Units of Service*
(Millions)



* A unit of service is an HMO month which is defined as a month in which one person is enrolled in a pre-paid health plan. Since some recipients may be enrolled for years and others for just one or two months, the number of HMO months in a year is used to measure growth trends rather than annual enrollment.

	1982	1983	1984	1985	1986
Units of Service*	40,389	104,271	461,972	686,624	892,865
Average Monthly Enrollment	3,366	8,689	38,497	57,219	74,405

Provider Reimbursement

Ensuring that quality health care is reasonably priced is an important concern. The current reimbursement structures vary by provider type, the services involved, requirements of law and prevailing economic circumstances.

The following section addresses significant developments associated with each major provider group during the last three fiscal years. A complete listing of dollars expended, average payments, and claims processed for each provider type is included in the graphs section of this report.

Reimbursing Hospitals

Fiscal Year 1984 saw the Department restoring many programs that had been reduced or eliminated earlier as part of the Emergency Budget Act of 1983. The $500 cap on each inpatient admission for General Assistance and Aid to the Medically Indigent clients continued until January 1, 1985. The lifting of the payment cap was made possible by the savings anticipated through the ICARE Program.

In Fiscal Year 1985, the search for quality care at a reasonable price resulted in the development of the ICARE Program. Beginning in June, contracts were signed with hospitals in the City of Chicago to provide 1,041,211 days of inpatient care to public aid recipients at an average daily cost of $424.68. This reflects an 8.25 percent decrease from the average Fiscal Year 1985 rate of $462.90. By the end of Fiscal Year 1986, all of the potential annualized utilization was under contract.

During Fiscal Year 1986, the Department concluded ICARE contract negotiations in all areas of the state where contracting was to occur. In 1986, contracts were in effect for 183 hospitals covering all the types of inpatient care Department recipients will need to receive in these geographic areas. Fiscal Year 1986 savings to Illinois taxpayers because of the ICARE benefits in the City of Chicago have been documented by independent review to be $84 million.

ICARE contracts are in effect covering approximately 1.7 million days of care annually. The Department continues to purchase an additional 150,800 days of care annually from hospitals in rural areas not included in ICARE.

Also during Fiscal Year 1986, the Department implemented the national hospital common claims form, UB 82. Public Act 83-1243, as passed by the Illinois General Assembly, required that all other payors in Illinois begin using the form in 1986.

Reimbursing Long Term Care Facilities

While continuing its cost-containment efforts, the Department looked for ways to improve the quality of care in long term care facilities. The Illinois Medicaid Program purchases both skilled and intermediate long term care for nearly 55,000 residents in approximately 750 nursing homes throughout the State. The long term care rate structure is based on cost reports submitted by each facility, and by patient assessment surveys. A per diem rate is calculated for each facility and is updated on July 1 each year.

In July 1986, the Department began an innovative approach for determining the nursing component of reimbursement to geriatric long term care facilities. This initiative included steps which promote preventive, restorative, and rehabilitative care. Under the old reimbursement system, the more dependent a resident became, the more reimbursement a facility received. The new system reimburses facilities for developing and implementing programs designed to increase residents' independence. These services include:

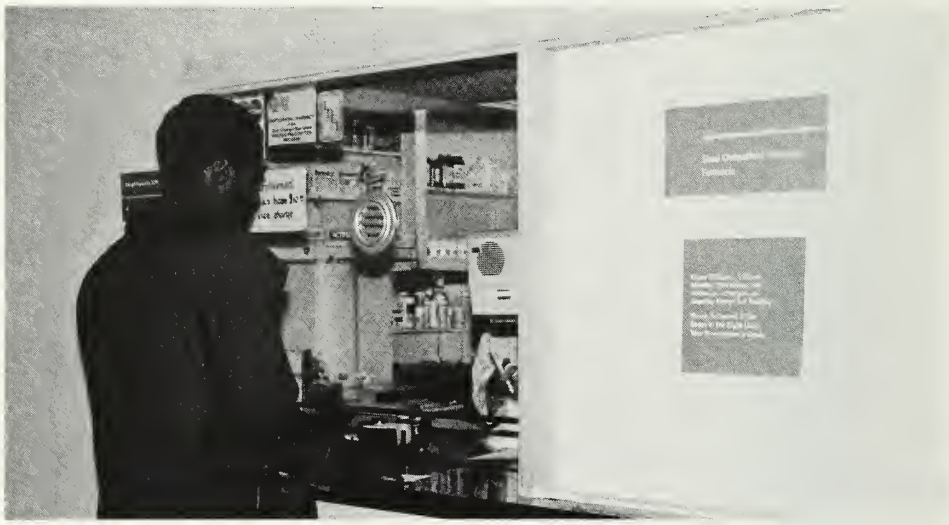
- retraining programs to help residents learn to eat, bathe, and dress independently;
- decubitus (bed sore) prevention programs that include repositioning, proper nutrition, and adequate hydration; and
- psychosocial programs that help residents address issues such as grieving and adjustment to nursing home life.

The most rewarding result of these new initiatives has been that nursing home staff has seen the effects these types of preventive, restorative, and rehabilitative programs have had on both the residents and on the morale of the facility staff. The following graph indicates the success of the initiative:

Comparison of the Old and New Reimbursement Systems

	Percent of Residents Scored as Independent	
	Old System	**New System**
Bathing	3.2%	25.4%
Clothing	11.3%	36.0%
Eating	29.1%	74.9%
Mobility	33.8%	47.6%
Toileting	44.1%	62.5%

In Fiscal Year 1987, the Department plans to implement similar changes for long term care facilities serving the developmentally disabled. To further improve the manner in which long term care is purchased, an Executive Task Force in Long Term Care Reimbursement was established in Fiscal Year 1986. This Task Force, consisting of legislators, industry representatives, Department staff and nursing home reimbursement specialists, will study the Department's current reimbursement system and explore changes and improvements.



Reimbursing The Individual Provider

Over 20,700 individual practitioners receive payments from the State for the medical services they provide recipients. Over nine million bills were processed and paid to those providers during Fiscal Year 1986. The number of participating providers by type of service is listed in Table IV.

Physicians

In Fiscal Year 1986, payments to physicians for care, including office and hospital visits, surgery, radiology, in-office laboratory tests, and dispensed drugs accounted for $159.7 million.

Physicians are reimbursed at their actual charges up to a statewide maximum established by the Department. Rates for most physician services were increased by five percent during Fiscal Year 1986. Emphasis was also placed on the provision of ambulatory services in the most appropriate setting, for example physician's office versus outpatient hospital service. Cost savings anticipated through restructuring the reimbursement system related to hospital ambulatory care permitted the Department to develop a system of add-on payments for certain procedures which could be safely performed in the office setting rather than in the outpatient hospital setting. The add-on "surgical pack" payment is a mechanism to compensate the physician for patient preparation and necessary supplies for procedures performed in the office. Over four hundred procedures have been identified as appropriately provided in the office setting. However, the decision to use a setting other than the office is at the discretion of the physician. The revised payment structure was implemented October 1986.

Dentists

Due to a $1.6 million surplus in Delta Dental Plan's portion of the program, improvements were made possible in the dental program. The main focus of this effort was to encourage dentists to participate in the program and to provide additional care for public aid clients. In determining the appropriate use of the surplus funds, a cooperative effort was made among the Department, Delta Dental Plan, the Illinois State Dental Plan, the Illinois State Dental Society, and the Department's Dental Advisory Committee.

The result of this effort was an eight percent increase in rates for most dental services effective October 1, 1986. In addition, fees were doubled for certain trauma procedures and coverage was added for root canal therapy on bicuspids and permanent first molars for children.

Additional enhancements have been scheduled to begin January 1, 1987. Services added include root canal therapy on anterior teeth for adults, the addition of apexification as a covered service for children, updating of bridgework services to current professional standards, and an additional fee increase for general anesthesia.

Paying for Prescribed Drugs

The Department's Pharmacology Board and the Illinois State Medical Society's Committee on Drugs and Therapeutics participate in an ongoing review of the various measures which control spending on prescribed drugs. All non-steroidal anti-inflammatory and anti-microbial drugs are allowed as of Fiscal Year 1986.

The Department reimburses pharmacies at the lowest of the usual charge to the general public, the actual acquisition cost or the Department's maximum allowable amount plus a dispensing fee.

Paying for Other Services and Practitioners

A variety of services and procedures are included under "other services." Appliances, transportation, laboratory services, other related medical services, supplementary medical insurance benefits (SMIB) premiums and payments to cover (in part or in whole) what Medicare does not pay (Medicare Scheduling) falls in this grouping. Reimbursement varies from maximum rates to prevailing rates. Medicare scheduling payments are directly affected by the reimbursement ceilings of Medicare and Medicaid.

The Department reimburses the services of registered nurses and audiologists at the prevailing community rate after verification by the local Public Aid office. Prior approval is required for speech, occupational and physical therapy. These professionals are reimbursed at a maximum rate per session.

Optometrists, podiatrists, and chiropractors are grouped in the category of "Other Practitioners." The Department pays these practitioners at their actual charge up to a statewide maximum established by the Department for each individual procedure. As with physician services, restructuring of the reimbursement system for hospital ambulatory care allowed the Department to increase the amount of funding available for these practitioners.

In the optical care program, a major restructuring occurred due to an arrangement made with the Illinois Department of Corrections. In addition, the requirement for prior approval of eyeglasses was eliminated. However, the Department continued its policy of limiting reimbursement to one pair of eyeglasses in a twelve-month period.

Appliances and Transportation

Prior approval is required for the purchase of appliances, such as braces, hearing aids, and air conditioners and is limited to either the maximum rate established by the Department or the most reasonable cost available in the client's geographic area. Prior approval is no longer required for the replacement or repair of items previously purchased by the Department if certain criteria are met. This program enhancement allows clients to have items that have already been determined as medically necessary to be promptly repaired or replaced. Transportation is paid at the actual charge up to the Department's maximum. Maximums vary by geographic area and mode of transportation to reflect cost differentials. Ambulance, medicar and service car providers receive a base rate plus a mileage rate. Ambulance and medicar providers may also receive supplements for certain medically necessary items such as oxygen. Commercial carrier (train, plane, bus) is approved on a case-by-case basis and reimbursed at either the prevailing or a negotiated rate.

Laboratory Services

Laboratories licensed by the State are eligible to be reimbursed for physician-requested tests related to diagnosis or treatment. Reimbursement is made at the actual charge up to a statewide maximum for each individual procedure.

Medicare and Supplementary Medical Insurance

The Department pays the cost of Supplemental Medical Insurance Benefits (SMIB) for Medicaid clients who are eligible for Medicare Part B (Medicare Scheduling). SMIB provides federal payments for medical bills incurred for non-institutional care. Similar to private medical insurance coverage, SMIB requires coinsurance and deductibles which are not paid within the coverage. For Medicaid clients, the Medicare Part B co-insurance and deductibles are paid to the provider by the Department up to the Department's maximum rate for each eligible service.

Prepaid Health Plans

During Fiscal Year 1986, the Department contracted with ten HMOs to provide case managed medical care to recipients. The money paid to the HMOs is based on a flat monthly rate per recipient that is negotiated with the HMOs. In Fiscal Year 1986, the Department through its HMO program provided comprehensive medical care to over 91,000 recipients.

Providing Care in the Home

Recipients may receive special medical services in their homes when needed. Intermittent or part-time nursing services, home health aid services, medical supplies, equipment and appliances (suitable for home use) as well as physical therapy are paid under home health care for all recipients except those on General Assistance.

A new program enhancement allows clients to have items that have already been determined as medically necessary to be promptly repaired or replaced.

Utilization And Control

In order to ensure that quality medical care is available to each client and that the care is reasonably priced, the Department measures and, to an extent, controls the use of medical services.

Utilization Measures

Utilization refers to the extent to which recipients make use of available medical services. Therefore, utilization is described in terms of expenditures, the number of eligible recipients, and the number of claims paid. Together these factors provide the best picture of current recipient and provider utilization trends.

Expenditures are used as one factor to measure utilization because this measure is sensitive to changes in the total volume of services purchased, changes in the types of services provided and changes in the rate of payment for each unit of service. Total expenditures alone, however, are not a primary measure of utilization trends. A dramatic cost increase would not necessarily indicate that utilization increased, nor that services to recipients were improved.

In order to calculate utilization for hospital inpatient care, group care, physician services, prescribed drugs, clinic services, hospital outpatient care and laboratory services, the average monthly number of recipients in all medical programs is used.

Average Monthly Number of Eligible Recipients	
Fiscal Year 1984	1,103,950
Fiscal Year 1985	1,116,707
Fiscal Year 1986	1,144,162

Because the services of "other practitioners," dentists and home health agencies are not provided to GA and AMI recipients (emergency dental services are covered, however), the average number of recipients used to calculate utilization data for these services excludes GA and AMI recipients.

Average Monthly Number of Eligible MAG and MANG Recipients	
Fiscal Year 1984	959,818
Fiscal Year 1985	983,144
Fiscal Year 1986	1,012,778

Utilization Controls

The Medicaid Program requires each participating state to perform a number of tasks to control utilization. These regulatory measures are called utilization controls and are designed to affect the behavior of providers and patients in regard to the quantity, quality, or type of medical services. These controls are applied at different times:

- Pre-delivery controls minimize improper use of medical services before it occurs,
- Concurrent review determines whether continuation of services is appropriate,
- Post-treatment review ensures that payments are limited to necessary services.

Pre-Delivery Controls. Existing reimbursement practices incorporate several pre-service delivery controls as cost-containment measures. Among the limits placed on hospitals are:

- surgery only in the most appropriate situation,
- a restricted list of available prescription drugs; and
- long term care reviews.

Prior approval for medical services is limited to those which are costly, potentially over-utilized, or of questionable medical necessity.

The Department has developed a strong Third Party Liability Program (TPL). As a result, Illinois recovered $17.8 million in Fiscal Year 1986 from Medicare and other payors for service initially paid by the Department. These collections are recovered from third parties such as insurance companies or Medicare after the Department has paid the medical expenses for public aid recipients. As part of this program, the Department also tries to avoid paying for services which should be paid by other liable parties (cost avoidance).

The federal government has mandated that all state agencies change their Third Party Liability Programs from the recovery model to one that relies on cost avoidance. Illinois has taken the steps necessary in this area to put into operation a viable cost avoidance system.

Representatives from the Third Party Liability Section meet with insurance carriers in Illinois on an ongoing basis, to explain the Department's TPL Program to enhance public relations in this area.

Recipient Restriction Program. The newly restructured Recipient Restriction Program (RRP) is an effort by the Department to ensure more effective utilization of health care services by recipients enrolled in the Medical Assistance Program. The concept of RRP is that through the use of primary care physicians and/or primary care pharmacies, as Health Maintenance Organizations, each recipient will receive appropriate and optimal medical services.

In addition to restriction based on overutilization, restriction can also be based upon recipients found to have loaned or altered their medical cards for the purposes of obtaining medical benefits to which they are not entitled or falsely representing medical coverage. Recipients found in possession of blank or forged prescription pads, and recipients who knowingly assist providers in rendering excessive services or defrauding the Medical Assistance Program are also restricted.

Post-Treatment Review. During the past fiscal years, the Department has greatly increased the Peer Review. Additional staff has been employed and additional consultant practitioners contracted to assure the best possible care is given to public aid recipients. The past fiscal years reflect the overall increase of the Peer Review Program.

1984 - Thirty-five physicians were reviewed; of these, eight were terminated and three were suspended.

1985 - Forty-seven physicians were reviewed; of these, 14 were terminated.

1986 - Fifty-six physicians were reviewed. Thirteen doctors were terminated. Eleven dentists were reviewed with three terminated.

Medicaid Management Information System

A new medical claims processing and management information system called MMIS (Medicaid Management Information System), under development for several years, was completely implemented in September 1981. This system was designed to improve the efficiency of the Illinois Medical Assistance Program through increased automation and standardization of claims processing activities, development of improved techniques for the detection of fraud and abuse, and the establishment of a more comprehensive management and administrative reporting system.

The Illinois MMIS, adapted from the federal model MMIS, is divided into six interrelated parts which function to accomplish the following objectives.

Recipient Subsystem. This system contains a file of all eligible recipients and is used to support claims processing edits designed to ensure medical payments are made to only those eligible for assistance. Also, data from this file are extracted for use in the Department's Medical Assistance Program to detect instances of provider or recipient fraud and abuse.

Reference Subsystem. This subsystem contains files of medical procedures, drug items, and diagnosis codes. It is used to support claims processing activities in determining the amount to be paid for services when payment is based on a fee-for-service and to supply data for auditing claims information.

Provider Subsystem. This subsystem contains a file of all Department approved providers with rate information for hospital, transportation, and health agency pricing. Information from these files support claims processing editing/pricing activities and contain necessary provider identification data used in creating a medical warrant for payment by the Comptroller's Office.

Claims Subsystem. This subsystem is used to process invoices submitted by providers of medical services. Interfacing with the Provider, Recipient, and Reference Subsystems, the Claims Subsystem assures that payment is made only if:

- the recipient is eligible;
- the provider is enrolled; and
- the service is covered by the Department.

Through MMIS, the Department can also detect unusual recipient or provider behavior and, therefore, reduce fraud and abuse.

If these criteria are met, the Claims Subsystem performs further checks to determine if the type of service provided was appropriate for the recipient's age group or sex, whether a service was paid previously that should preclude paying this claim, and what amount should be paid for the service. Data relating to each paid claim is carried through the Claims Subsystem for use in detection of fraud and abuse (SURS) and management reporting (MARS).

Surveillance and Utilization Review Subsystem (SURS). Public Aid's vendors, along with clients, have learned of the effects of this system over the past fiscal years. Each year, greater development of the system enables the Department to accomplish the goals of SURS:

- to develop a comprehensive statistical profile of health care delivery and utilization patterns,
- to reveal suspected instances of fraud or abuse of the Medicaid Program by individual providers and recipients,
- to provide information indicating the existence of any potential defects in the level of care or quality of service.

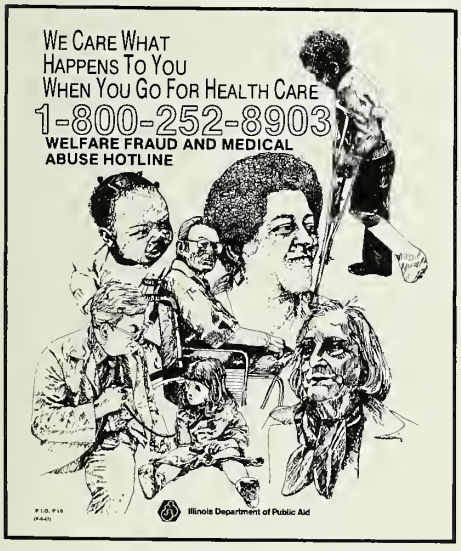
Management and Administrative Reporting System. Using data from the Provider, Recipient, Reference, and Claims Subsystems, reports are generated that are designed to furnish the Department with information to support the management review, evaluation, and decision-making process; to provide management with financial data or fiscal planning, information to monitor the progress of claims processing, and data to analyze provider and recipient performance in terms of the extent and nature of services received and the adequacy of participation; and to provide necessary data to support federal reporting requirements.

MMIS continues to strengthen the Department's ability to monitor all aspects of the Medical Assistance Program and to accurately project expenditures. Most importantly, it ensures that recipients receive quality care.

Halting Fraud and Abuse. Through MMIS the Department can also detect unusual recipient or provider behavior and, therefore, reduce fraud and abuse. It does this by storing and analyzing data which may be indicative of fraud and abuse behavior.

During Fiscal Year 1986, the Bureau of Medical Quality Assurance sought and obtained the termination of 54 Medicaid providers. A portion of these providers were terminated in conjunction with the Department of State Police and the undercover work of the late Senator Prescott Bloom. This activity resulted in the passage of legislation that improved the Department's ability to detect fraudulent Medicaid practices and recover monies paid.

An important safety check against provider fraud is the Department's formal audit program. Audits of hospitals and nursing homes are conducted by IDPA and on a contractual basis by the Health Care Service Corporation (Chicago Blue Cross) and public accounting firms. The Department audits each in-state participating hospital every year, while accounting firms audit nursing homes. The Department will continue to expand its auditing capability as a check against Medicaid fraud.



Contract Monitoring

The Department has responsibility for ensuring that each contracting hospital remains in compliance and is providing good quality care. As a part of this process, the Department's staff are responsible for visiting hospitals on a regular basis and tracking their provision of care over time. By guiding the use of care, program savings are also maintained.

As an additional effect of the ICARE Program, recipients now have a voice concerning the quality and type of medical care that they receive in hospitals. The office established a 24-hour, bilingual, toll-free hotline to answer questions from recipients or medical staff. Any complaints are quickly followed up to rectify problems between recipients and hospitals. Recipients can receive timely information concerning the contract status of hospitals which ensures good access to medical care. This also makes efficient use of the care that is available statewide.

To further assess and maintain good quality medical care, the Department contracted with a professional Peer Review Organization (PRO) under the ICARE Program. The Crescent Counties Foundation for Medical Care (CCFMC), which performs a similar function for Medicare, was chosen to be the PRO for this program. Under its agreement with the Department, it conducts reviews for medical necessity and quality of care. For general care, it reviews 40 percent of admissions to hospitals under contract with the Department. In addition, it certifies all specialty care to public aid recipients. CCFMC also works with Utilization Review and Quality Assurance Departments within hospitals to help them improve their performance. Non-contracting hospitals are also required to have their true emergency services certified by CCFMC. These measures enable the Department to assess the quality and appropriateness of the medical care provided under the ICARE Program.

To effectively communicate its policies and procedures, the Department has frequent contact with hospitals. Departmental hospital liaisons visit hospitals to answer questions and clarify policy for hospital staff. Hospitals have a way of communicating their concerns to the Department. These efforts are supplemented by the information and education program of CCFMC. Assistance is provided in the proper preparation and processing of claims for services rendered to public aid recipients.

These efforts increase the efficiency of the information and payment systems. They also improve and sustain good working relationships with those who provide good medical care in hospital settings. Illinois public aid recipients now have improved access to good, modern medical care and have a full scope of inpatient hospital care available to them.

An important safety check against provider fraud is the Department's formal audit program.

Future Directions

During Fiscal Year 1987, some of the Department's major initiatives will be improving the lives of children, expanding services to help substance abusing clients break away from drug and alcohol habits, and continuing emphasis on halting program fraud and abuse.

Healthy Kids

The Department is pursuing several enhancements to the Healthy Kids Program:

- development and implementation of medical and dental standards governing program services;
- improving timeliness standards to increase the efficient delivery of services;
- expanded use of community-based agencies to deliver outreach, follow-up and case management services to clients residing in areas of high infant mortality; and
- improved methods for providing assistance to clients in accessing medical providers and arranging transportation to and from medical appointments.

The Department believes these current and future activities will result in more children receiving Healthy Kids services. More importantly, children will be healthier and really have a "chance that lasts a lifetime."

Alcohol and Substance Abuse

The Department, in conjuction with the Department of Alcohol and Substance Abuse, is developing a new medical program to help alleviate problems associated with alcoholism and substance abuse. The program will include:

- the provision of outpatient services;
- the provision of detoxification services; and
- the provision of limited rehabilitative services.

Fraud and Abuse

During Fiscal Year 1987, the Department, through the Bureau of Medical Quality Assurance, will continue to seek legislation to combat fraud and abuse. With greater cooperation of federal, state, and local law enforcement agencies, the Department will further enhance its efforts in fraud detection.

Collections

During Fiscal Year 1987, the implementation of a state-of-the-art on-line accounts receivable system is planned. This system will integrate the identification of third-party resources and payments received into one comprehensive on-line system.

Also in Fiscal Year 1988, the Department plans to recover TPL funds from clients or former clients in long term care facilities.

Mental Health Clinic Option

The Department of Public Aid in conjunction with the Department of Mental Health and Developmental Disabilities is developing a program of clinic services for the mentally ill that will meet Medicaid standards and will result in enhanced services while qualifying for federal matching funds. The program is expected to be operational in Fiscal Year 1987.

Nurses Aide Training

Project Chance is funding a training program directed toward placing 600 recipients into nursing homes as certified nurses aides. The nurses aides will be employed throughout the State and will increase the number of qualified staff available to nursing homes. The increase in certified staff will enhance the quality of care provided to nursing home residents while reducing welfare rolls.

Extended Medical Coverage

An initiative is planned for Fiscal Year 1988 to provide extended medical coverage to clients who lose their public aid income due to employment. The extended coverage is intended to offer the client an additional incentive to obtain and maintain employment. This program will be very beneficial to clients who find jobs with employers who provide no or minimal health benefits.

All aspects of the Medical Assistance Program are designed to do more than just pay the bills, but rather to give the poor a chance to live healthy and sound lives, to help them become contributing citizens. Meeting these goals with a strong commitment to growth and progress will mean that no one in need will be denied access to quality medical care.

"Ensuring quality medical care while providing efficient management of tax dollars is an enormous undertaking . . . . The Department of Public Aid will successfully meet this challenge."

Edward T. Duffy, Director.

Table I Group Care Total Charges and Payments for Fiscal Years 1984-1986

	Group Care-All			Skilled Nursing			Intermediate		
	FY 84	FY 85	FY 86	FY 84	FY 85	FY 86	FY 84	FY 85	FY 86
Total Charges* ($ millions)	$609.7	$655.4	$748.5	$154.3	$144.2	$145.0	$455.4	$511.2	603.5
Total Payments* ($ millions)	$437.9	$476.1	$518.3	$111.5	$106.5	$100.3	$326.4	$369.5	418.0
Total Patient Days (millions)	20.1	19.8	20.4	4.7	4.0	3.6	15.4	15.8	16.8
Average Per Diem Rate	$30.38	$33.09	$36.69	$32.84	$35.94	$39.88	$29.57	$32.37	36.00
Average State Per Diem Payment	$21.82	$24.04	$25.41	$23.65	$26.55	$27.61	$21.21	$23.40	$24.93
Ratio of Payments	0.72	0.73	0.69	0.72	0.74	0.69	0.72	0.72	0.69

*"Charges" are costs allowed by the State's reimbursement system. "Payments" are that portion of charges paid by the State, half of which are later reimbursed by the federal government. The difference between charges and payments is the amount paid by patients or other third party payors toward the cost of care. Figures presented above exclude lump-sum payments or other reimbursements not directly connected to daily patient care.

Table II Fiscal Year 1986 Medical Expenditures by Eligibility Category and Provider Type* ($ millions)

Category	MAG			MANG			GA			AMI			Total		
	Total State	Cook County	Down-State	Total State	Cook County	Down-State	Total State	Cook County	Down-State	Total State	Cook County	Down-State	Total State	Cook County	Down-State
Total	695.4	486.2	209.2	925.8	460.8	456.7	89.7	89.7	0.0	63.5	38.1	25.3	1774.4	1074.8	691.2
Hospitals	416.1	282.5	133.7	242.5	153.8	88.7	61.7	61.7	0.0	53.0	34.0	19.1	773.3	532.0	241.5
Inpatient	352.3	240.0	112.4	224.6	141.7	82.9	55.0	55.0	0.0	51.0	33.2	17.8	682.9	469.9	213.1
Outpatient	48.0	27.9	20.1	13.9	8.4	5.5	5.3	5.3	0.0	1.9	0.7	1.3	69.1	42.3	26.9
Clinic	15.8	14.6	1.2	4.0	3.7	0.3	1.4	1.4	0.0	0.1	0.1	0.0	21.3	19.8	1.5
Group Care	4.1	2.7	1.4	538.4	234.0	304.4	0.1	0.1	0.0	0.5	0.2	0.2	543.1	237.0	306.0
Practitioners	138.4	85.9	52.3	39.6	21.5	18.2	15.5	15.5	0.0	7.9	3.3	4.6	201.4	126.2	75.1
Physicians	108.1	65.3	42.8	31.0	16.2	14.9	13.2	13.2	0.0	7.4	3.1	4.3	159.7	97.8	62.0
Dentists	24.0	16.2	7.8	6.4	4.0	2.4	2.3	2.3	0.0	0.5	0.2	0.3	33.2	22.7	10.5
Optometrists	4.6	3.5	1.1	1.7	1.0	0.7	0.0	0.0	0.0	0.0	0.0	0.0	6.3	4.5	1.8
Podiatrists	1.1	0.9	0.1	0.4	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.2	0.2
Chiropractors	0.6	0.0	0.5	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.0	0.6
Drugs	65.3	47.3	18.0	72.4	32.1	31.8	9.1	9.1	0.0	1.6	0.4	1.2	148.4	88.9	51.0
Other Medical	20.1	16.4	3.8	32.9	19.4	13.6	3.3	3.3	0.0	0.5	0.2	0.2	56.8	39.3	17.6
Laboratories	9.0	8.4	0.6	1.9	1.5	0.4	2.9	2.9	0.0	0.2	0.1	0.1	14.0	12.9	1.1
Transportation	3.7	2.6	1.1	7.2	5.0	2.2	0.3	0.3	0.0	0.1	0.0	0.1	11.3	7.9	3.4
Medicare Sched.	1.0	0.9	0.2	5.7	3.1	2.6	0.0	0.0	0.0	0.0	0.0	0.0	6.7	4.0	2.8
SMIB	1.3	1.1	0.2	7.2	4.0	3.3	0.0	0.0	0.0	0.0	0.0	0.0	8.5	5.1	3.5
Home Health Care	1.8	1.4	0.4	4.2	1.9	2.3	0.0	0.0	0.0	0.0	0.0	0.0	6.0	3.3	2.7
Appliances	2.3	1.3	1.0	3.9	2.2	1.7	0.1	0.1	0.0	0.1	0.0	0.0	6.4	3.6	2.7
Other Related	1.0	0.7	0.3	2.8	1.7	1.1	0.0	0.0	0.0	0.1	0.1	0.0	3.9	2.5	1.4
HMO	51.4	51.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	51.4	51.4	0.0

*These numbers are estimates because certain expenditures such as some C-13 (voucher) payments are not linked to specific individuals and, therefore, are not tied to eligibility category.

NOTE: Numbers may not add up exactly due to rounding

Table IIIa. Medical Assistance Program - Twelve Month Expenditures

Category	FY 84 Dollars	Percent	FY 85 Dollars	Percent	FY 86 Dollars	Percent
Total	1,564,280,287	100.0%	1,681,804,291	100.0%	1,774,900,991	100.0%
Hospitals	787,841,409	50.4%	803,175,743	47.8%	773,330,465	43.6%
Inpatient	713,862,163	45.6%	716,615,993	42.6%	682,939,852	38.5%
Outpatient	55,332,734	3.5%	64,738,943	3.8%	69,081,247	3.9
Clinic	18,646,513	1.2%	21,820,807	1.3%	21,309,366	1.2%
Group Care	437,870,367	28.0%	492,627,203	29.3%	543,128,316	30.6%
Practitioners	149,343,034	9.5%	166,639,702	9.9%	201,589,572	11.4%
Physicians	121,683,049	7.8%	135,288,389	8.0%	159,685,626	9.0%
Dentists	22,237,175	1.4%	25,335,579	1.5%	33,428,974	1.9%
Optometrists	4,124,754	0.3%	4,330,038	0.3%	6,284,516	0.4%
Podiatrists	976,091	0.1%	1,235,095	0.1%	1,459,840	0.1%
Chiropractors	321,965	.0%	450,601	.0%	730,615	.0%
Drugs	114,115,870	7.3%	129,379,265	7.7%	148,367,219	8.4%
Other Medical	47,492,935	3.0%	47,929,872	2.8%	57,071,070	3.2%
Laboratories	12,562,123	0.8%	12,349,453	0.7%	13,909,976	0.8%
Transportation	9,936,546	0.6%	9,851,097	0.6%	11,366,452	0.6%
Medicare	7,810,094	0.5%	6,158,049	0.4%	6,809,919	0.4%
SMIB	7,255,812	0.5%	7,483,236	0.4%	8,565,557	0.5%
Home Health Care	3,048,186	0.2%	4,400,869	0.3%	6,048,205	0.3%
Appliances	3,970,478	0.3%	4,622,015	0.3%	6,424,457	0.4%
Other Related	2,909,695	0.2%	3,065,153	0.2%	3,946,504	0.2%
HMO	27,616,671	1.8%	42,052,506	2.5%	51,414,349	2.9%

Table IIIb. Medical Assistance Program - Expenditures Against Appropriation*

Category	FY 84 Dollars	Percent	FY 85 Dollars	Percent	FY 86 Dollars	Percent
Total	1,580,148,461	100.0%	1,693,304,214	100.0%	1,722,045,863	100.0%
Hospitals	782,770,492	49.5%	807,533,287	47.7%	743,072,460	43.2%
Inpatient	707,253,854	44.8%	722,793,535	42.7%	656,804,671	38.1%
Outpatient	57,671,365	3.6%	63,749,813	3.8%	66,221,108	3.8%
Clinic	17,845,273	1.1%	20,989,939	1.2%	20,046,682	1.2%
Group Care	454,785,611	28.8%	493,937,451	29.2%	529,462,740	30.7%
Practitioners	150,730,769	9.5%	168,762,401	10.0%	189,790,576	11.0%
Physicians	123,468,298	7.8%	134,597,094	7.9%	152,591,053	8.9%
Dentists	21,814,068	1.4%	28,119,637	1.7%	29,019,085	1.7%
Optometrists	4,137,682	0.3%	4,345,127	0.3%	6,080,720	0.4%
Podiatrists	985,010	0.1%	1,242,001	0.1%	1,383,651	0.1%
Chiropractors	325,710	.0%	458,542	.0%	716,066	.0%
Drugs	116,515,806	7.4%	132,560,360	7.8%	144,084,229	8.4%
Other Medical	47,729,112	3.0%	48,458,209	2.9%	64,221,509	3.7%
Laboratories	12,622,019	0.8%	12,348,495	0.7%	22,228,099	1.3%
Transportation	9,750,860	0.6%	9,903,491	0.6%	10,901,318	0.6%
Medicare	7,973,711	0.5%	6,052,306	0.4%	6,474,473	0.4%
SMIB	7,255,812	0.5%	8,216,721	0.5%	8,541,278	0.5%
Home Health Care	3,309,884	0.2%	4,250,875	0.3%	5,861,746	0.3%
Appliances	4,061,490	0.3%	4,690,867	0.3%	6,262,869	0.4%
Other Related	2,755,336	0.2%	2,995,454	0.2%	3,951,726	0.2%
HMO	27,616,671	1.7%	42,052,506	2.5%	51,414,349	3.0%

*The total of fiscal year percentages for all service categories may not equal 100% due to rounding.

Twelve month spending is reported by presenting total expenditures from July through June, regardless of which fiscal year's appropriation is the source of the funds.

Spending against appropriation is spending made against a given year's appropriation and can occur during the fiscal year (July - June), or during the lapse period (July - September).

Table IV Participating Medicaid Providers by Type of Service[1]

	Fiscal Year 1984	Fiscal Year 1985	Fiscal Year 1986
Hospitals	280	280	279
Clinics	53	52	59
Nursing Homes[2]	749	756	777
Physicians	16,926	17,170	17,821
Dentists	2,272	2,057	1,957
Optometrists	518	440	396
Podiatrists	316	333	348
Chiropractors	234	225	272
Pharmacies	2,848	2,874	2,929
Laboratories	174	165	152
Transportation	591	581	640
Home Health	246	238	292
Other Providers	460	613	606
HMOs	2	6	10
Totals	25,669	25,784	26,538

1. All medical services provided to Medical Assistance Program clients are provided either by licensed practitioners such as physicians and dentists or licensed facilities enrolled to participate in the state's program.

2. The "Nursing Homes" category does not include state-operated long-term care facilities.

NOTE: The number of nursing homes presented is not consistent with previous annual reports. It was discovered that earlier reports counted a nursing home which changed ownership during the year as two facilities. This problem has been eliminated for this report and the court for all years. (FY 84, 85, & 86) reflects the unduplicated number of facilities.

Table V Illinois Medical Assistance - Mandatory/Optional Services

Mandatory Services Provided

Inpatient hospital care
Outpatient hospital care
Other laboratory and x-ray services
Rural health clinic services
Skilled nursing and home health services for individuals 21 and older
Early and periodic screening, diagnosis and treatment for individuals under 21
Family planning services
Physicians services
Emergency Ambulance transportation

Optional Services Provided

Clinic services
Prescribed drugs
Dental services
Prosthetic devices
Eyeglasses
Dentures
Physical therapy
Occupational therapy
Speech, hearing, and language therapy
Diagnostic services
Preventive services
Rehabilitative services
Private duty nursing
Emergency hospital services

Optional Services (Continued)

Skilled nursing facility services for individuals under 21
Optometrists' services
Podiatrists' services
Chiropractors' services
Other practitioners' services
Christian Science Sanitoria
Christian Science nurses
Care for individuals 65 or older in TB institutions
Care for individuals 65 or older in institutions for mental disease
Care for individuals under 21 in psychiatric hospitals
Institutional services in intermediate care facilities
Intermediate care for the mentally retarded
Personal care
Adult screening services

With the exception of adult screening, Christian Science nurses and personal care, Illinois covered all optional services for MAG recipients in Fiscal Year 1986.

Comprehensive coverage was also available to all AABD-MANG clients and medically needy children. The remaining medically needy adult population received basic coverage in Fiscal Year 1986, under the Basic Health Protection Plan.

Services covered under the comprehensive plan but no longer covered under the basic plan include: outpatient hospital or clinic care (with some exceptions;) medical procedures performed by podiatrists, chiropractors and optometrists; and dentures, eyeglasses and certain other non-vital appliances and supplies. Only vital drugs are now covered. Dental services were limited to emergency services necessary to combat infections or relieve pain.

This report was prepared to meet the obligation of Ill. Rev. Stat., Ch. 23, Sec. 5-5 requiring the Department to report annually concerning:

- "actual statistics and trends in utilization of medical services by Public Aid recipients,
- actual statistics and trends in the provision of the various medical services by medical vendors,
- current rate structures and proposed changes in those rate structures for the various medical vendors, and
- efforts at utilization review and control by the Illinois Department."

For more information, write the Department's Office of Public Information, Jesse B. Harris Building, 100 South Grand Avenue East, Springfield, Illinois 62762.

The Illinois Department of Public Aid does not discriminate in admission to, treatment, or employment in programs or activities in compliance with the Illinois Human Rights Act, the Illinois Constitution, the U.S. Civil Rights Act, Section 504 of the Rehabilitation Act, as amended, and the U.S. Constitution.

Printed by the authority of the State of Illinois, April 1987, P.O. 60441, 3,000 copies. DPA 8121.

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